ABSTRACT

BARRIERS TO ACCESS TO HEALTH CARE AMONG LATINO IMMIGRANTS IN THE UNITED STATES: A QUANTITATIVE STUDY

By

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The purpose of this study was to explore the barriers of access to health care amongst the Latino immigrant population in the United States. This was accomplished by performing a quantitative study analyzing secondary data obtained from the California Health Interview Survey (CHIS). The results revealed that Latino immigrants with lower level of English proficiency had fewer doctor's visits, reported lower levels of acculturation, and the majority were born in Mexico whom reported having no health insurance in the entire year. The variables of gender, citizenship status, general health status, and insurance coverage within the past 12 months had a strong correlation with the utilization of the emergency room. The findings may be beneficial in providing awareness to the barriers Latino immigrants face while accessing health care services in the United States.

BARRIERS TO ACCESS TO HEALTH CARE AMONG LATINO IMMIGRANTS IN THE UNITED STATES: A QUANTITATIVE STUDY

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INTRODUCTION

Problem Statement

According to the U.S. Census Bureau (2010), 16.3% of the United States population is of Latino/Hispanic origin. The total number of Hispanic immigrants in 2009 was 18.1 million (Betalova & Terrazas, 2010). The American Community Survey (ACS) estimated 12 million of the 18.1 million foreign born Hispanic immigrants were solely from Mexico. In 2010, the Hispanic population was 50.5 million in comparison to 35.3 million in 2000 (U.S. Census Bureau, 2010). There was a 43.0% increase in the Latino/Hispanic population in the United States from 2000-2010 (U.S. Census Bureau, 2010). The Latino immigrant population is one of the largest in the United States. There are several needs amongst this population in the United States that have been unmet, for instance access to health care insurance and lack of culturally competent health care services.

The Latino immigrant population is at risk of mental health disorders as a result of acculturation; Escobar, Nervi, and Gara (2000) found that people who recently emigrated from Mexico have lower risks of mental health problems considering the strong family bonds within their network and strong support systems. The higher level of acculturation increases the level of demand in economic productivity as a result of the United States labor force.

The economic demand can increase the expectations of success of acculturated Latino immigrants, resulting in stress that can escalate to depression (Marsiglia, Kulis, Perez, & Bermudez-Parsai, 2011). Although immigrants have variety of strengths, as a result of familialism, the additional barriers encountered are the challenge of inadequate jobs, housing difficulties, health insurance barriers, difficulties of learning a new language/culture, laws, and anti-foreign society (Marsiglia et al., 2011).

The anti-immigrant sentiments can be related to Proposition 187, which was passed by the State of California voters. According to the American Civil Liberties Union (n.d.) the United States Congress determined the law unconstitutional due to the attempt to implement blockage to health care, education, and law enforcement verifying legal status of all members in a Latino immigrant family. Difficulties in obtaining resources change in culture, and anti-immigrant sentiments can increase the vulnerability to mental health problems such as depression and hopelessness for Latino immigrants (Marsiglia et al., 2011). Although Proposition 187 was vetoed, Latinos in the United States of Mexican ancestry have lower rates of health insurance coverage in comparison to non-Mexican Latinos (Bustamante, Fang, Rizzo & Ortega, 2009).

Purpose Statement

The purpose of this study was to explore the barriers of access to health care amongst the Latino immigrant population in the United States.

Research Questions

This study was conducted by utilizing secondary data from the 2012 California Health Interview Survey (CHIS). The research explored the following research questions:

1. How often are health care services accessed by Latino/Mexican immigrants?

2. What is the relationship between language barrier and years of residing in the United States and Latino/Mexican immigrants' access to health care and use of emergency room visits?

3. How are demographic characteristics associated with Latino/Mexican immigrants' access to health care and utilization of emergency room?

Definition of Terms

Latino: Native inhabitant of Latin America, a person of Latin American origin living in the United States (Latino, 2003).

Immigrant: A person who comes to a country to take up permanent residence (Immigrant, 2003).

Mexican: A native or inhabitant of Mexico, or a person of Mexican descent (Mexican, 2003).

Language barrier: Difficulty in expressing or communicating with the majority population (Kim et al., 2011).

CHAPTER 2

LITERATURE REVIEW

The Latino immigrant population faces several barriers to accessing health care in the United States. According to Gusmano and Berlinger (2013) there is an estimated 11.2 million Latino immigrants originating from Latin countries, and more than half are from Mexico. The United States health care system, politics, physical environment, and social norms have a significant negative effect on vulnerable populations such as immigrants, minority groups, low socioeconomic status families, and women (Marshall, Urrutia-Rojas, Mas, & Coggin, 2005). The vulnerability of the Latino immigrant population creates discrimination and marginalization because of federal restrictions increasing the barriers to accessing health care amongst Latino immigrants because of their fears to deportation, or feelings of oppression (Edward, 2014).

Lack of access to health care is directly correlated to the length of stay for immigrants in the United States, immigration status, and language availability (Akincigil, Mayers, & Fulghum, 2011). Nandi et al. (2008) found a significant correlation between years of stay in the United States and obtaining health care services amongst immigrants. Akincigil et al. (2011) concurred that length of stay in the United States, immigration status and language ability are part of the barriers in accessing health care amongst Latino immigrants. Gresenz, Rogowski, and Escarce (2009) indicated Hispanics face numerous barriers, including both financial and nonfinancial barriers.

Gusmano and Berlinger (2013) found that Latino immigrants often migrate in search of jobs in the United States and accept positions that require low education levels, are physically demanding, and provide low wages. Collins, Villagran, and Sparks (2008) concluded Latino participants in their research experienced high levels of frustration when attempting to access medical screenings and fail to connect to the health care resources. In the qualitative study one of the Latina participants shared she found a suspicious lump but was unable to be examined by medical staff due to the financial barriers and lack of medical insurance; Latino immigrants often seek medical services across the Mexico border.

Leung, LaChapelle, Scinta, and Olvera (2014) found similar results regarding the frustration immigrants feel when attempting to access health care. In their research participants experienced depressive symptoms due to the frustration of not being able to access health care thus preventing them from attempting to access mental health services or physical health care services. The participants in the research by Salas, Ayón, and Gurrola (2013) shared a common thread of feeling oppressed due to the limited mobility their legal status creates. Participants in this study heard rumors within their community warning them not to go seek medical services at local hospitals because the sheriff was in the area along with agents from homeland security. Furthermore, Salas et al. concluded Latino immigrants felt traumatized because of the symptoms of high anxiety, hopelessness, and distress due to the confinement they face from all the barriers.

Demographic Barriers

There are several demographic barriers Latino immigrants face while attempting to access health care services. According to Gresenz et al. (2009) racial and ethnic compositions of neighborhoods are responsible for some of the inconsistencies in obtaining health insurance. Findings by Villa, Wallace, Bagdasaryan, and Aranda (2012) found that Hispanics have higher possibilities in experiencing unemployment or underemployment, reside in segregated neighborhoods with fewer healthcare resources, and have access to schools with low academic levels that lack funding from the state. Marshall et al. (2005) studied gender influences, health status, social roles, cultural behavior patterns, and access to healthcare funding distribution. They concluded that funding of healthcare resources is distributed by gender related cultural needs. Akincigil et al. (2011) reported some Latino immigrant neighborhoods have developed higher quality of informal communication of healthcare resources availability within their community.

The research of Collins et al. (2008) concurred that organizational factors within the healthcare system contribute to health organizations providing minimal clinical necessities, routine procedures to minorities, and lower quality of health services. Free clinics provide care for the uninsured patient, low-income workers, and the left over population who cannot access safety net programs (Gertz, Frank, & Blixen, 2011). A research study identified 172 free clinics in the United States; 44% of the clinics were independent, and 86% of their patients utilized the free clinics as their primary care providers (Gertz et al., 2011).

Participants shared a high level of satisfaction with the free clinics and stated that if their current attending free clinic were to be closed they would seek another free clinic for primary care services or women's health care (Gertz et al., 2011). Research shows that in 1980, 30 million people were uninsured. This number has increased in the past 25 years by 50% and the number of free clinics increased significantly co-occurring with the increased number of the uninsured (Gertz et al., 2011).

Some United States residents who live along the Mexico border are illegal immigrants with lower socioeconomic status; therefore there is a minimal level of support from the United States government to provide national health care assistance (Collins et al., 2008). A major limitation of the Affordable Care Act is the exclusion of illegal immigrants to access state and federal insurance coverage that is available for purchasing (Rosen, 2014). Some United States citizens are concerned about the Affordable Care Act (ACA) weakening the support for programs and providers who serve low income, uninsured residents (Gusmano & Berlinger, 2013).

The Latino immigrant population faces a variety of limitations to accessing health care due to inapplicable aspects such as immigration and health care policy reforms that have been implemented in the past decades (Edward, 2014). The Patient Protection and Affordable Care Act includes restrictions to accessing health care for Latino immigrants, increasing concerns amongst the health care providers and policymakers in the United States (Edward, 2014). Therefore, Latino immigrants cannot access social security numbers or other documentation offered federally or at the state level due to the implementation of state immigration laws.

Without the proper documentation, public health services and health insurance are denied due to required identification forms (Edward, 2014). The anti-immigrant laws contribute to rumors that are filtered throughout the Latino communities and instill fear in accessing health care services (White, Yeager, Menachemi, & Scarinci, 2014). Furthermore, immigrants who attempt to access resources face a barrier of transportation: they are unable to navigate through the predominantly English language transportation system, which increases their unfamiliarity with their surroundings (Akincigil et al., 2011). Rogers (2010) stated that participants in the study wanted health care community providers to enhance their resource availability by advertising and providing a safe environment where participants feel respect and receive culturally competent services.

Legal Documentation

Lack of legal documentation is also determined to be a significant barrier for immigrants (Marshall et al., 2005). Undocumented Mexican immigrants represent part of the vulnerable population and are a higher risk of health/medical disease and/or serious injuries (Nandi et al., 2008). Participants in the research by Coffman, Shobe, and O'Connell (2008) shared fear of being deported due to utilizing health care services and receiving a bill for a large amount of money. The research by White et al. (2014) indicated the current anti-immigrant laws that continue to block immigrants from services: The Taxpayer and Citizen Protection Act, House Bill 56 (HB 56), was passed in Alabama in 2011; similar laws were passed in Arizona, Georgia, Indiana, South Carolina, and Utah. The laws require individuals who attempt to access health care

services from local agencies to provide documentation of legal status (White et al., 2014). Proposition 187 added revisions to California law to prevent Latino immigrants from seeking state funded medical services with the exception of emergency services (Wang, 1995). In the recent economic status in the United States, there has been an implementation of reduction of health care spending for United States citizens and legal immigrants, creating specific blockage to these services for undocumented Latino immigrants (Edward, 2014). The research by White et al. also indicates that local and state law enforcement agencies have the power to verify legal residency while performing routine traffic stops; due to this procedure, immigrants will limit travel outside their home and reduce possibilities of accessing local health care services.

The participants in Salas et al.'s (2013) study indicated that when they knew the sheriff was in town they would stay home, would not go to work, take the children to school, or do any other activity outside of their home due to the fear of being detained and deported. The lack of documentation increases stress levels in Latino immigrants because they are unable to provide proper documentation when stopped by law enforcement or if there is proof of legal documentation participants indicated they have to consistently carry it in order to show proof of legal residence (Salas et al., 2013). The Latino immigrants who work without legal documentation tend to work in jobs that do not provide vacation leave, medical benefits, overtime compensation, and are not able to collect unemployment if they are suffering from a medical condition.

The participants in a study by Dang, Giordano, and Kim (2012) had been diagnosed with HIV and were hesitant to request time off for fear of being laid off and avoided seeking medical services due to fear of deportation. The participants were also asked by medical agencies to provide proof of employment and annual gross income but are unable to provide work documentation as low skilled jobs are only paid cash by employers (Dang et al., 2012). In another qualitative study the access to documentation to a variety of Latino immigrants created social barriers within their Latino immigrant community; participants shared that immigrants who did not have legal documentation were less supportive to immigrants who had legal documentation and were able to obtain higher quality jobs with better benefits (Smith & Mannon, 2010).

Emergency Room Visits

Latino immigrants with limited social networks are less likely to access health care services within their community. Akincigil et al. (2011) showed that Latino immigrants tend to utilize emergency room visits more often than the average citizen in the United States. The lack of preventative care increases the possibilities of Latino immigrants utilizing emergency room services for health conditions that could have been prevented with regular doctor visits (Akincigil et al., 2011). The research outcomes of Akincigil et al. showed a considerable number of young immigrants utilizing the emergency room in lieu of accessing preventative care. The findings also indicated young immigrants utilize emergency room services more frequently due to the lack of knowledge of availability of resources within their community.

The lack of treatment of preventative health care services increases the possibilities of a person utilizing the emergency room, due to the fear of discrimination from local health care staff and the assumption of emergency room services being free (Akincigil et al., 2011). Coffman, Norton, and Beene (2012) reported that participants in their study felt that emergency room services had a lower cost found than primary care services and felt safer receiving services from the emergency room. Coffman et al. (2008) indicated in their research Latino immigrants only attended emergency room visits when the need was immediate and at times they would be forced to go to the emergency room since they do not have a primary care physician and have delayed in seeking services for acute illnesses. Edward (2014) adds the inability for Latino immigrants to obtain health care insurance creates an inability to pay for their health care costs, creating nonrefundable costs for the hospital, and having the hospital pay out of pocket for services rendered to Latino immigrants.

Ku and Matani (2001) concluded that the United States only provides access to emergency services for citizens, creating a gap of services for immigrants who are non-citizens since they are ineligible for state insurance coverage. Gertz, Frank, and Blixten (2011) discovered in their research that 47% of their participants chose to utilize free clinics, 22.6% chose to use emergency room services, and 15.2% chose public hospitals. Edward (2014) concludes that access to preventative health care services would improve community health and decrease the spending on health care. In the literature of Latino participants 57% reported utilizing the emergency room for primary care services, all of the participants reported not having insurance.

Fewer than 10% of the participants reported utilizing free clinics due to the lack of free clinics within their community. The Researcher in the study indicated the access to primary care services drastically decreases the rate of emergency room service utilization. Participants also shared they would not seek medical services if the free clinics were not established, indicating that due to the lack of free clinics participants would seek care via emergency room services (Khan, Velazquez, O'Connor, Simon, & De Groot, 2011). Akincigil et al. (2011) indicated the utilization of emergency room services has been linked to location of services; due to the increase of Latino immigrants there has been an increase of immigrants migrating to rural areas or small towns where there is a limited number of community healthcare resources. Some private healthcare facilities are not willing to receive state funded insurance such as Medicaid or Medi-cal, and Latino immigrants do not have access to resources in comparison to emergency room services being easier access (Akincigil et al., 2011).

Gender

According to Gresenz et al. (2009) Latino women who obtain health care services usually have stronger social networks with bilingual friends, in order to help utilize services. Collins et al. (2008) indicated some Latina women may choose to avoid health care services that would limit their family responsibilities or role as woman in their family. Gurman and Becker (2008) concurred with the role of *familismo* in the Hispanic family dynamics of women. The research shows women's experience with health care services is influenced by their family or social networks. The anti-immigrant laws affect women and children due to the need of health care services such as prenatal care and well

doctor visits (White et al., 2014). Pregnant women did not want to connect to prenatal health care services because of fear of being rejected by health care providers for not being able to provide proof of legal residency status (White et al., 2014). Latina women in a study by Salas et al. (2013) experienced high levels of stress fearing their husbands would not return home from work due to being detained by local law enforcement for lack of documentation. The study also concluded that mothers in the study felt nervous when applying for social services for their children and being questioned by caseworkers as a result of the anti-immigrant laws (Salas et al., 2013). Latino immigrant parents who have children born in the United States do not usually access health care for their children although their children qualify for health care services (Gusmano & Berlinger, 2013).

A mother in a study shared that because there was lack of language interpreters, she was unable to place her baby for adoption. Her initial plans were to provide a better home for her newborn but the hospital did not provide an interpreter (Gurman & Becker, 2008). Wells, Lagomasimo, Palinkas, Green, and Gonzalez (2013) indicated that Latinas culturally follow a sense of respect with doctors and Latina patients often do not share feelings of their medical diagnosis or their malcontentment with medical services. In the study by Salas et al. (2013) Latinos shared their frustration and stress they experienced when they do not have financial resources to provide for their family, creating marital conflicts such as fighting in the home with their spouse while the children are present. The only coping tool males utilized was to remain quiet and attempt to find work or go to work with the fear of deportation (Salas et al., 2013).

Carvajal et al. (2013) highlighted in their research that men who are farm workers had higher levels of stress and depressive symptoms. As discussed earlier in the research Latino immigrants tend to obtain low skill jobs such as being a farm worker. The health outcomes of men and women who work in the fields had a significant association to poor health and impact in mental health. A study by Solorio, Forehand, and Simoni (2013) indicated the main barrier to HIV testing is the fear of rejection, stigma, and being labeled as *sidoso* (a person who has AIDS). The fear of a positive test creates avoidances for males to receive health services. In a study by Vissman et al. (2009) Latino male participants shared that the reason for not utilizing protection during sexual encounters was because their partners appeared healthy and there was no reason to seek medical services for sexually transmitted diseases or human immunodeficiency virus.

Language Barriers

Kim et al. (2011) found in their research that Latino immigrants with limited English proficiency are more vulnerable, are inconsistent in accessing health care, and have poorer health. Garcia and Duckett (2009) indicated that participants in their research shared a common theme of a language barrier being the key source to not accessing health care services. Their inability to schedule appointments via telephone, interact with providers during their doctors visit, comprehend the discharge planning, and paperwork provided only in English, causes communications problems and misunderstanding. Ku and Matani (2001) indicated monolingual Latino parents had their children misdiagnosed by the physicians due to the language barrier and misunderstanding physicians' orders.

Kim et al. (2011) indicated that people with limited English proficiency have fewer doctor visits for preventive care screenings for cervical and breast cancer and are less likely to obtain care than those who speak fluent English. Akincigil et al. (2011) found a correlation between limited English proficiency and accessing health care for immigrants who speak English, causing difficulty in communicating their symptoms when they are ill. When people are ill they tend to have difficulty in self-disclosure, and participants indicated that self-disclosure is easier in their native language (Akincigil et al., 2011). Kim et al. found that people with limited English proficiency are at higher risk of not understanding prescription medication instructions and are unable to comprehend medical situations. The inability to understand medical situations creates the lack of understanding personal rights and informed consent (Kim et al., 2011). The research of Coffman et al. (2008) indicated that due to the inability to understand medication labels monolingual Spanish speaking participants chose not to go to the pharmacy for medication.

A participant in the research by Coffman et al. (2008) shared the frustration of not being able to understand the medications regardless of the number of times he would go to the pharmacy. At times if bilingual staff were present, often the individual had to wait long periods of time, and often felt his confidentiality was violated due to the information being shared in a non-private area such as the doctor's office (Gurman & Becker, 2008). Akincigil et al. (2011) found that Latino immigrants feel they have been discriminated against, due to their low English proficiency; therefore they feel mistrust in the medical system and their treatment by the healthcare providers.

The anti-immigrant laws are contributing to the mistreatment immigrants experience by local healthcare agencies and their staff who provide discriminatory customer service by racial profiling of immigrants who attempt to access health care services (White et al., 2014). Coffman et al. (2008) shared that the lack of culturally competent language and messages regarding health care services add to the health disparities due to the Latino patients not being able to identify with the American biomedical approach to health care services. Wells et al. (2013) agreed that language barrier or miscommunications with American medical providers contribute to the hesitation or objection to accept American health care services.

Vissman et al. (2009) indicated in their study that Hispanic males who sought medical services often did not understand the directions given by medical providers or did not express clear concerns due to language barriers. Latino immigrants who receive services in their native language shared feeling a positive interaction with the health care staff (Garcia & Duckett, 2009). Latino immigrants' participants indicated they faced language barriers when attempting to access resources for HIV services. They shared not being able to understand the health care system, the information provided to the participants at times was difficult to understand, the staff that was provided for translation purposes lacked translating skills and did not provide the correct translated information due to the mixture of English and Spanish words, and the translators at times did not understand the Spanish spoken by the participants (Dang et al., 2012).

Alternative Options for Health Care

Bergmark, Barr, and Garcia (2010) explored the reasons Mexican immigrants in the United States return to Mexico for medical services. The sample consisted of Mexican immigrants who live in Northern California and people living in Michoacán, Mexico who had previously lived in the United States. The results found that the majority of the interviewees had returned to Mexico for medical services. According to Bergmark et al. participants return to Mexico for medical services were because of their unsuccessful medical treatment in the United States, cost of care, and preference for Mexican health care services. Bergmark et al. indicated that unsuccessful medical care led them to the border of Mexico or to their home states in Mexico. Some of the participants shared that doctors in the United States were not able to diagnose or help with a difficult illness and the only solution was to return to Mexico. Participants shared that the cost of health care was high and they were not able to afford services. Consequently, participants moved back to Mexico as health care treatment was denied due to their illegal residency status.

Latino immigrants participants in the research by Coffman et al. (2008) indicated that the thought of high cost of medical care immediately made them feel better and they avoided the symptoms. Akincigil et al. (2011) reported that Mexican immigrants are aware of the universal health care coverage Mexico provides. The preference for Mexican health care services was shared by participants because of comfort of language preference and knowledge and experience with the Mexican healthcare system (Bergmark et al., 2010). Coffman et al. concurred that there is preference of Mexican

health care due to Mexican doctors informing patients directly of their diagnosis and providing details of treatment and answering their questions directly. In their study a participant shared his dissatisfaction with the styles of communication he received from the U.S health care system. Research by Collins et al. indicated levels of acculturation significantly influenced their participants' self-identification with the United States health care system or the Mexico health care system. A study by Coffman et al. indicated that Latino immigrant barriers were high cost, out of pocket deductible, fear of deportation and choosing to self-prescribe medication. United States Latino residents who live along the border states travel to Mexican border for self-prescribed medication (Coffman et al., 2008). Latinos who obtain medication in Mexico often only seek medical opinions from pharmacist or family members that are not medically qualified (Coffman et al., 2008). Some Latinos who cannot obtain medications by travelling to the border, travel to nearby Latino markets who sell illegal medication (Coffman et al., 2008).

The research by Coffman et al. (2008) suggested that Latinos chose local Latino markets due to the familiarity of the product, language, and options to different medication. Rhodes et al. (2011) concurred with the selling of medication that in the United States would only be sold via prescription; participants were able to purchase medication that was not expired, sealed/unbroken, ready to ingest via capsules or injections. The medication was obtained through Hispanic community stores, community members, and/or churches. The medication was provided in Spanish language packaging and instructions (Rhodes et al., 2011). Vissman et al. (2009) agreed that *tiendas* (a community store usually established in swap meets or local commercial shopping malls)

was a form of comfort or familiarity for finding support in the community, a location where monolingual Spanish speaking Latino immigrants could seek health care resources. Buyers often do not have difficulties in obtaining medication through community stores. In fact, the availability of the medication is fast and networking within the community is attainable in their native language, affordable, and the medication was culturally congruent (Rhodes et al., 2011). The availability of medication without prescriptions is not only available through Hispanic community stores but also via the internet; an individual does not have to have a prescription or doctor's visit, only internet access (Rhodes et al., 2011). Although medication is attainable through community Hispanic stores, the majority of the medication was not appropriate for the symptoms or medical condition the individual was experiencing, and the symptoms or medical condition was not resolved (Rhodes et al., 2011). Some participants in the study by Coffman et al. shared they often sought free medical care by attending free clinics or health fairs.

Although participants sought free medical care through health fairs, the services provided at the health fairs have a high demand within the community and there is a limitation on services provided. The research by Collins et al. (2008) shared that some Latinos utilized Mexican folk healers (*curanderos*) as traditional health care treatments in the United States. Other participants, indicated in White et al. (2014) are using home remedies for their health conditions or over the counter medications instead of choosing local health care agencies because of the anti-immigrant laws that were passed.

Summary

The literature review included research studies that examined the limitations of English proficiency, access to health care amongst undocumented Mexican immigrants in a United States urban area, use of Mexican border health care services, community demographics, health care access amongst Latino women, the stressors between genders, and emergency room utilization by Mexican immigrants. The literature discussed the barriers that Mexican/Latino immigrants face while attempting to access health care services within their community. The literature suggested Latino immigrants have difficulty in accessing health care primarily due to language barriers, documentation status, gender, income level, and levels of acculturation and length of stay in the United States. The outcomes of these barriers provide Latino immigrants with minimal health care options. Vissman et al. (2009) concluded that in order to reduce the gap amongst vulnerable communities, a development of interventions targeting health problems must be formed. Latino immigrants are facing and creating partnerships with community leaders for networking and building rapport with community members. Latino immigrants who face these barriers must increase their social network support, increase self-awareness of services within their community, depend on emergency services due to lack of preventative services, travel out of the country for health care services, or return to their native country.

CHAPTER 3

METHODOLOGY

Research Design

This research used a quantitative methodology. The secondary was used to explore Mexican immigrants' access to health care. The secondary was obtained from the California Health Interview Survey (CHIS, 2012). The California Health Interview Survey was administered in a collaborative work-study by UCLA Center of Health Policy Research and the California Department of Public Health and Department of Health Care Services. The interviews were conducted by phone and via computer assisted telephone dialing to landlines and cellular phones (CHIS, 2012).

Sample and Data Collection

The researchers self-administered surveys or questionnaires. The California Health Interview Survey is the largest survey conducted nationwide. The survey is based on the California state population and conducted bi-annually via telephone survey (CHIS, 2012). The phone interviews were processed amongst multi-generational homes. The respondents were randomly selected by household via phone and data was collected from one adult to carryout CHIS 2011-12 adult surveys. The interviews were conducted in five different languages; English, Spanish, Chinese, Vietnamese, and Korean. The total number of interviews conducted for the years 2011-2012 was 53,068 (CHIS, 2012).

The survey topics for the California Health Interview Survey (2012) were access to and use of health care, community services offered and utilization of services, and different topics of health care and general demographic information. For the purpose of this study, the researcher used non-probability, purposive sampling to select 200 adults who identified themselves as Mexican Americans and immigrants.

Data Retrieval Form

The Data Retrieval Form (Appendix A) used in this study consists of 25 variables. The variables are related to the research questions. The variables are categorized into three sections consisting of demographics characteristics, health condition, and health insurance. The demographic section includes gender, age, ethnicity, immigration status, length of stay in the United States, and legal residency. The health condition section consists of personal rating of general health. The health care access section consists of emergency room visits, number of emergency room visits per year, access to doctor or medical office, language utilized during doctors' visits, and level of understanding.

Data Analysis

The researcher utilized the Statistical Package for the Social Sciences (SPSS) to analyze the retrieved secondary data. The researcher utilized chi-square tests to test research questions and frequency distribution tables were used to describe all the variables.

Social Work Ethics

The CHIS data did not provide any identifiers; therefore, ensures anonymity of the subjects. The UCLA Center for Health Policy utilized the Data Access Center (DAC) that provided researchers with the opportunity to utilize confidential files in a secure, controlled environment protecting the confidentiality of respondents (CHIS, 2012). The CHIS files are stored in the detailed geographic identifiers, with completed demographic information for survey respondents (CHIS, 2012).

Relevance to Social Work and Older Adults and Families Concentration

The Latino Immigrant population is growing rapidly in the United States. In cities throughout California the need for health care services exist. The Latino population faces several barriers in accessing health care services. As social workers working with older adults and families, it is professional duty to help families connect to health care services. The utilization and linkage of health care services can better serve the largest immigrant population. The limitations for this research have been fear of the Latino immigrant to be researched by government agencies. This study provides social workers with knowledge about the need of health care service for the Latino Immigrant population.

Relevance to Social Work Practice and Multicultural Social Work

There are a variety of cultural differences in the United States' society. The immigrant population is the fastest growing population in the United States. There is a diverse background of immigrants arriving to the United States.

The immigrant population is in need of resources including health care services. This research provides a better understanding of how to help the immigrant population, not only for Latinos but also for all those with diverse ethnic backgrounds.

Limitations to the Study

There are several limitations to this study. Primarily the immigrant population is difficult to research. There are several barriers to obtaining information about Latino immigrants. Many Latino immigrants do not want to share personal information or participate in any surveys, due to fear of stigma, legal status and/or negative legal repercussions.

CHAPTER 4

RESULTS

Demographic Characteristics of the Study Sample

The demographics are presented in Table 1. The total sample was 2,648 Latino adults who were born outside the United States. The ages of the sample were 18-45 years. The genders of the samples were 1,042 males (39.4%) and 1,606 females (60.6%). The majority (n = 2,240; 84.6%) were from Mexico, 309 (11.7%) were from Central America, others (3.7%) were other Latin countries. The citizenship statuses include 694 (26.2%) naturalized citizens and 1,954 (73.8%) were non-citizens.

TABLE 1. Demographic Characteristics (n = 2,648)

Characteristics	*n*	%
Gender		
Male	1,042	39.4
Female	1,606	60.6
Ages		
18-25	339	12.8
26-35	895	33.8
36-45	1,414	53.4
Years Lived in the United States		
1 Year	34	1.3
2-4 Years	99	3.7

TABLE 1. Continued

Characteristics	*n*	%
5-9 Years	396	15.0
10-14 Years	629	23.8
15 + Years	1,490	56.3
Citizenship Status		
Naturalized Citizen	694	26.2
Non-Citizen	1,954	73.8
Latino/Hispanic Subtypes		
Mexico	2,240	84.6
Other Countries	408	15.4
Language spoken at home		
English	71	2.1
Spanish	1,202	45.4
English & Spanish	1,327	50.1
Other	48	1.7
Language Used during interview		
English	634	23.9
Spanish	2,014	76.1
English Use and Proficiency		
Speak Only English	71	2.7
Very Well/Well	917	34.6
Not Well/not at all	1,660	62.7
Any Insurance in Last 12 Months		
Currently Uninsured	1,053	39.8
Uninsured any past 12 months	232	8.8
Insured all past 12 months	1,363	51.5
Emergency Room Visit in the past year		
Yes	382	14.4
No	2,266	85.6
General Health		
Poor	60	2.3
Fair	662	25.0
Good	1,111	42.0
Very good	461	17.4
Excellent	354	13.4

Bivariate Results

There is a statistically significant association between English use and proficiency and number of doctor visits, ($X^2 = 8.225$, df = 6, and $\square = .006$) (Table 2). Among those who have not /not at all speaking English well (32.9%) had no doctor visits in the past 12 months. There is a significant association between years lived in the United States and number of doctor visits (X^2= 17.506, df=6 and $p = .008$). Among the sample that indicated living in the United States for less then 9 years, 34.8% did not visit the doctor. There is a significant relationship between birth country and number of doctor visits, (X^2=10.553, df=3 and $p = .04$). Among those who were born in Mexico (29.7%) had no doctor visits (Table 6). There is a significant relationship between citizenship status and number of doctor visits (X^2=30.481, df=3 and $p = .005$).

Among those who were naturalized citizens (22.2%) had no doctor visits. There is a significant relationship between general health conditions and number of doctor visits (X^2= 113.523, df=12 and $p = .005$) (Table 2). Among those with poor general health, only (13.3%) reported no doctor visits. There is a significant relationship between uninsured all year and number of doctor visits (X^2= 176.141, df=6 and $p = .005$). Among people who were uninsured all year (43.6%) did not visit the doctor. There is a significant difference between males and females in the number of doctor visits (X^2= 163.111, df=3 and $p = .005$). Among the females, (22.0%) did not have doctor visits. There is no significant association between age and number of doctor visits (X^2= 7.016, df=6, and $p = .319$).

TABLE 2. Difference in Doctor Visits (n = 2,648)

	Doctor Visits						
	0	1-3	4-6	7more	X^2	df	p
English Use							
Speak only English	15 (21.1%)	39 (54.9%)	12 (16.9%)	5 (7.0%)	18.225	6	.006
Very well/well	240 (26.2%)	477 (52.0%)	114 (12.4%)	86 (9.4%)			
Not well/not at all	546 (32.9%)	757 (45.6%)	202 (12.2%)	155 (9.3%)			
Years lived in the US							
Less than 9 years	184 (34.8%)	219 (41.4%)	72 (13.6%)	54 (10.2%)	17.506	6	.008
10-14 years	202 (32.1%)	308 (49.0%)	64 (10.2%)	55 (8.7%)			
15 and more years	415 (27.9%)	746 (50.1%)	192 (12.9%)	137 (9.2%)			
Country Born							
Mexico	665 (29.7%)	1,103 (49.2%)	263 (11.7%)	209 (9.3%)	10.553	3	.014
Other countries	136 (33.3%)	170 (41.7%)	65 (15.9%)	37 (9.1%)			
Citizenship Status							
Naturalized citizen	154 (22.2%)	382 (55.0%)	93 (13.4%)	65 (9.4%)	30.481	3	.005
Non-Citizen	647 (33.1%)	891 (45.6%)	235 (12.0%)	181 (9.3%)			
General Health							
Poor	8 (13.3%)	15 (25.0%)	16 (26.7%)	2 (35.0%)	113.523	12	.005
Fair	180 (27.2%)	295 (44.6%)	121 (18.3%)	66 (10.0%)			
Good	343 (30.9%)	544 (49.0%)	130 (11.7%)	94 (8.5%)			
Very Good	144 (31.2%)	238 (51.6%)	37 (8.0%)	42 (9.1%)			
Excellent	126 (35.6%)	181 (51.1%)	24 (6.8%)	23 (6.5%)			
Country Born							
Mexico	665 (29.7%)	1,103 (49.2%)	263 (11.7%)	209 (9.3%)	10.553	3	.014

TABLE 2. Continued

	Doctor Visits						
	0	1-3	4-6	7more	X^2	df	p
Other	136 (33.3%)	170 (41.7%)	65 (15.9%)	37 (9.1%)			
Insurance in past 12 months							
Uninsured all year	388 (43.6%)	415 (46.6%)	62 (7.0%)	25 (2.8%)	176.141	6	.005
Uninsured part year	106 (26.8%)	179 (45.3%)	56 (14.2%)	54 (13.7%)			
Insured all year	307 (22.5%)	679 (49.8%)	210 (15.4%)	167 (12.3%)			
Gender							
Male	447 (42.9%)	461 (44.2%)	90 (8.6%)	44 (4.2%)	163.111	3	.005
Female	354 (22.0%)	812 (50.6%)	238 (14.8%)	202 (12.6%)			
Age							
18-25	112 (33.0%)	157 (46.3%)	38 (11.2%)	32 (9.4%)	7.016	6	.319
26-35	281 (31.4%)	432 (48.3%)	96 (10.7%)	86 (9.6%)			
36-45	408 (28.9%)	684 (48.4%)	194 (13.7%)	128 (9.1%)			

TABLE 3: There is a statistically significant relationship between English use proficiency and emergency room visits (X^2 =13.98, df=2, and p=.001). Among those who spoke only English (28.2%) visited the Emergency Room. There is no significant relationship between years lived in the United States (X^2=4.705, df=2 and p= .095) and country of origin (X^2=.108, df=1, and p= .743) with emergency room visits. There is a significant relationship between citizenship status and emergency room visits, (X^2=5.641, df=1 and p= .018). Among those who were naturalized citizens 17.1% visited the

emergency room within the past year. There is a significant relationship between general health condition and emergency visits (X^2=74.180, df=4 and p=.005). Among those who had poor health condition, more than half (48.3%) visited the emergency room in the past year. There is a significant relationship between uninsured in the past 12 months and emergency room visits (X^2=46.775, df=2 and p= .005). Only (7.9%) who were uninsured all year visited the emergency room. There is a significant difference between males and females in visiting the emergency room (X^2=15.989, df=1 and p= .005). Among the females (16.6%) visited the emergency room in the past year. However, there is no significant association between age and emergency room visits (X^2=1.188, df=2 and p= .552)

TABLE 3. Difference in Emergency Room Visits (n =2,648)

	Yes	No	X^2	df	p
English Use Proficiency					
Speak Only English	20 (28.2%)	51 (71.8%)	13.198	2	.001
Very Well/Well	141 (15.4%)	776 (84.6%)			
Not well/not at all	221	1,43			
Years lived in the US					
Less than 9 years	65 (12.3%)	484 (87.7%)	4.705	2	.095
10-14 years	83 (13.2%)	546 (86.8%)			
15 and above	234 (15.7%)	1,256 (84.3%)			
General Health					
Poor	29	31	74.180	4	.005

TABLE 3. Continued (n =2,648)

	Emergency Room Visits				
	Yes	No	$x2$	df	p
	(48.3%)	(51.7%)			
Fair	121	541			
	(18.3%)	(81.7%)			
Good	137	974			
	(12.3%)	(87.7%)			
Very Good	48	413			
	(10.4%)	(89.6%)			
Excellent	47	307			
	(13.3%)	(86.7%)			
Country Born					
Mexico	321	1,919	.108	1	.743
	(14.3%)	(85.7%)			
Other	61	347			
	(15.0%)	(85.0%)			
Uninsured in past 12 months					
Uninsured all year	70	820	46.775	2	.005
	(7.9%)	(92.1%)			
Uninsured part year	69	326			
	(17.5%)	(82.5%)			
Insured all year	243	1,120			
	(17.82%)	(82.2%)			
Gender					
Male	115	927	15.989	1	.005
	(11.0%)	(89.0%)			
Female	267	1,339			
	(16.6%)	(83.4%)			
Age					
18-25	52	287	1.188	2	.552
	(15.3%)	(84.7%)			
26-35	120	775			
	(13.4%)	(86.6%)			
36-45	210	1,204			
	(14.9%)	(85.1%)			

TABLE 4: There is no significant relationship between English use proficiency and delay in obtaining prescription medication, (X^2=.490, df=2, and p=.783). There is no association between years lived in the United States and delay in obtaining prescription, (X^2=3.969, df=2, and p=.137). There is no significant association between country of origin and delay in obtaining prescription, (X^2=3.66, df=1, and p=.545). There is no significant relationship between citizenship status and delay in obtaining prescriptions, (X^2=.033, df=1, and p=.857). There is a significant relationship between general health and delay in obtaining prescription, (X^2=70.974, df=4, and p=.005).

Among those with poor health condition (33.3%) reported having delay in obtaining prescription in the past 12 months. There is a significant association between uninsured in the past 12 months and delay in obtaining prescription (X^2=13.166, df=2, and p=.001). Among those uninsured in the past 12 months (8.3%) had delays in obtaining prescriptions. There is a significant difference between males and females in having delay in obtaining medication (X^2=14.781, df=1, and p=.005). More females (12.0%) indicated having delay in obtaining medication in the past year when compared to males (7.4%). There is no significant association between age and having delay in obtaining prescription medication in the past 12 months (X^2= 4.493, df=2, and p=.106).

TABLE 4. Difference in Having Delay in Obtaining Prescription (*n* =2,648)

	Yes	No	X^2	df	p
English Use Proficiency					
Speak Only English	9 (12.7%)	62 (87.3%)	.490	2	.783
Very Well/Well	93	824			
Not well/not at all	168	1,492			
Years lived in the US					
Less than 9 years	45 (8.5%)	484 (91.5%)	4.705	2	.095
10-14 years	58 (9.2%)	571 (90.8%)			
15 and above	167 (11.2%)	1,323 (88.8%)			
General Health					
Poor	20 (33.3%)	40 (66.7%)	176.141	6	.005
Fair	102 (15.4%)	560 (84.6%)			
Good	96 (8.6%)	1,015 (91.4%)			
Very Good	32 (6.9%)	429 (93.1%)			
Excellent	20 (5.6%)	334 (94.4%)			
Country Born					
Mexico	225 (10.0%)	2,015 (90.0%)	.366	1	.545
Other	45 (11.0%)	363 (89.0%)			
Uninsured in past 12 months					
Uninsured all year	74 (8.3%)	816 (91.7%)	13.166	2	.001
Uninsured part year	59 (14.9%)	336 (85.1%)			
Insured all year	137 (10.1%)	1,226 (89.9%)			
Gender					
Male	77 (7.4%)	965 (92.6%)	14.781	1	.005
Female	193 (12.0%)	1,413 (88.0%)			

TABLE 4. Continued Delay in Obtaining Prescription

	Yes	No	X^2	df	p
Age					
18-25	33	306	4.493	2	.106
26-35	77 (8.6%)	818 (91.4%)			
36-45	160 (11.3%)	1,254 (88.7%)			

CHAPTER 5

DISCUSSION

Summary Findings

The study analyzed the correlation of number of doctor visits, emergency room visits, and delay in obtaining prescription medication to gender, years lived in the United States, citizenship status, country of origin, insurance coverage, and general health. The study found number of doctors visits to be significantly correlated to English language proficiency, years lived in the United States, country of birth, citizenship status, general health, insurance coverage and gender. The study indicated that participants who did not visit the doctor had lower levels of English language proficiency such as not well or not at all able to speak English, 34.8% indicated lower levels of acculturation, 29.7% of participants were born in Mexico, 43.6% were uninsured all year, and higher number of males reported not visiting the doctor.

The utilization of emergency room services was significantly correlated to English language proficiency, citizenship status, general health, general health, uninsured in the past 12 months, and gender. The results indicated that (13.3%) of the participants who did not speak English well or not at all, (48.3%) participants who had poorer health conditions, and (16.6%) of participants that identified as females reported visiting the emergency room.

The study found there is a significant association between delays in obtaining prescription medication with general health, insurance coverage and gender. The participants (33.3%) who had poor general health indicated having a delay in obtaining medication.

Comparison of Study Findings with Prior Research

The study of a prior research indicated that immigration status and Mexican heritage had a significant impact on access to health care and utilization of services (Durden & Hummer, 2006). In comparison to the current study, the findings indicated there was a significant relationship with citizenship status to number of doctors' visits and emergency room visits. The current study concurred with prior research in country of heritage being significantly correlated to access to health care, indicated participants born in Mexico had lower number of doctors visits. Prior research has found for language proficiency levels to have significant interrelationship with accessing health care, understanding medical procedures, continuation of care and assumption of high cost medication Wells et al. (2013).

In the present research, language proficiency had a significant interrelationship with the number of doctor visits and English language proficiency. Participants whose English level proficiency was lower reported higher number of not visiting the doctor, in comparison to English only participants. The number of participants categorized as limited having lower English levels decreased as number of visits increased. On the contrary with current research there was not a powerful parallel between English level proficiency or delay in obtaining medication due to assumption of high cost. The present

study did not find age to be correlated to utilization of emergency room, visiting the doctor, and having delay in obtaining prescription medication. In a previous study there was a strong connection between access to health care and depressive symptoms due barriers Latino immigrants face while connecting to medical resources and facing language barriers (Leung et al., 2014). The current study revealed high numbers of participants of Mexican descent having zero doctors' visits and higher emergency room visits in comparison to other countries.

Implications for Social Work Practice

This study is relevant to social work practice because as part of the National Association of Social Workers' (NASW) Code of Ethics, there is an obligation to be culturally capable and have awareness of social diversity, therefore one will most likely work with the Latino immigrant population who are facing barriers to accessing health Care in the United States. It is imperative for social workers to have awareness in the hidden barriers Latino immigrant face in the health care system. Staff working with the Latino immigrant population need to be adequately trained in order to better serve the population while attempting to access, manage, and maintain health care resources Cristancho, Garces, Peters and Mueller (2008). Social workers need to further understand the fear the Latino immigrant population face when navigating the health care system, lack of legal documentation and their lack of English proficiency, and discrimination from health care staff (Cristancho et al., 2008). Social workers who work in the health care field need to be aware of the fear Latino immigrant population experience; they need to be able to provide empathy and attempt to reduce personal fears

by providing culturally competent social work services, and socially ethical information regarding their treatment. There is a need for macro social workers to advocate in policy. Strategies to implement job based health insurance for immigrant workers and to improve the benefits that have been previously established through California State funding for immigrants (Ku & Matani, 2001).

Implications for Future Research

The Latino immigrant population will continue to increase. The need for health care resources and usage of health care resources will consequently increase. Future research is needed in the area of community interventions aimed at reducing the stigma that Latino immigrant population face when attempting to access resources. Furthermore research of continuation of care is needed in order to reduce utilization of emergency room visits as primary care, language barriers, and culturally competent health care staff. Additionally implementations of health care staff trainings and awareness aimed at increasing the understanding of Hispanic heritage and their perceptions on utilization of health care services. Overall research is essential with reference to Latino immigrant population by reason of fear to provide general information due to the stigma they face as immigrats residing in the United States.

Limitations of the Study

The limitations encountered in this study were regarding research findings. The majority of the research was from the East coast and center states of the United States. There were a variety of articles from North Carolina, Utah, and Texas, however, there were minimal results from the state of California. The findings of the study were solely

focused upon the Latino immigrant population; however the barriers are also faced by immigrants from various nationalities. The vulnerable population of immigrants is not only identifiable with Latinos as immigrants from other countries likewise face language barriers, lack of insurance coverage, low acculturation levels, low skill job availability, jobs requirements of harsh working conditions, access to state funded medical insurance for emergency care with the exception to primary care benefits or full insurance benefits due to lack to documentation.

Conclusion

This study has demonstrated the significant components that contribute to the barriers encountered by Latino immigrants while accessing health care services in the United States. Despite the limitations of the study, there is a need for continuation of research to investigate the barriers faced by immigrants and analyze changes within the health care system and further interventions within the Latino immigrant community. The United States nation has an obligation to address the longstanding unmet needs of the immigrant population due to policies that have been implemented to deny services and lack of culturally competent health care services. The immigrant population is generally portrayed in a negative manner and often categorized as the main cause of state/national funding exhaustion. The United States citizens often hear messages from the media addressing the negative impact immigration has on the country, however, the benefits that are contributed by the immigrant population are often dismissed. The findings of this study validated the need of health care access for Latino immigrants in the United States.

APPENDIX:

ACCESS TO HEALTH CARE AMONG THE LATINO IMMIGRANT POPULATION

SURVEY

ACCESS TO HEALTH CARE AMONG THE LATINO IMMIGRANT POPULATION SURVEY

Data Retrieval Form

I. Demographic Characteristics

1. What is your age, please?

_____years of age

2. Are you male or female?

Male
Female

3. Are you Latino or Hispanic?
Yes
No

4.
What languages do you speak at home?

a. English
b. Spanish
c. Other 1 (specify:_____)

5.
Since you speak a language other than English at home, we are interested in your own opinion of how well you speak English. Would you say you speak English…

a. Very well
b. Well,
c. Not well, or
d. Not at all?

6.
The next questions are about citizenship and immigration.
Are you a citizen of the United States?

a. Yes
b. No
c. Application pending
d. Refused
e. Don't know

7. Are you a permanent resident with a green card? Your answers are confidential and will not be reported to Immigration Services.

a. Yes
b. No
c. Application pending
d. Refused
e. Don't know

8. About how many years have you lived in the United States?

_____ Number of years

II. Health Condition

13. Would you say that in general your health is excellent, very good, good, fair, or poor?

a. Excellent
b. Very good
c. Good
d. Fair
e. Poor

III. Health Insurance

14. What kind of place do you go to most often—a medical} {Is your doctor in a private} doctor's office, a clinic or hospital clinic, an emergency room, or some other place?

a. Doctor's office/Kaiser/other hmo
b. Clinic/health center/hospital clinic
c. Emergency room
d. Some other place (specify:_____)
e. No one place

15. During the past 12 months, did you visit a hospital emergency room for your own health?

Yes
No
Don't know

16. During the past 12 months, how many times did you visit a hospital emergency room for your own health/How many times did you do that?

_____ Number of times

17. During the past 12 months, how many times have you seen a medical doctor?

_____ Times

18. About how long has it been since you last saw a doctor about your own health?
    a. One year ago or less
    b. More than 1 up to 2 years ago
    c. More than 2 up to 5 years ago
    d. More than 5 years ago
    e. Never
    f. Don't know

19. What is the ONE MAIN reason why you did not have any health insurance during those months?
    a. Can't afford/too expensive
    b. Not eligible due to working status/
    c. Changed employer/lost job
    d. Not eligible due to health or
    e. Other problems
    f. Not eligible due to citizenship/
    g. Immigration status
    h. Family situation changed
    i. Don't believe in insurance
    j. Switched insurance companies,
    k. Delay between
    l. Can get health care for free/pay
    m. For own care

Other (specify:_____)

20. During the time that you were uninsured, did you try to find health insurance on your own?

    a. Yes
    b. No

21. How difficult was it to find a plan with the coverage you needed? Was it…
    a. Very difficult
    b. Somewhat difficult

c. Not too difficult, or
d. Not at all difficult?

22. How difficult was it to find a plan you could afford? Was it…
e. Very difficult
f. Somewhat difficult
g. Not too difficult, or
h. Not at all difficult?

23. How often does your doctor or medical providers explain clearly what you need to do to take care of your health? Would you say…
a. Never
b. Sometimes
c. Usually
d. or Always?

24. In what language did the doctor speak to you?

a. English
b. Spanish
c. Other (specify:_____)

25. Did you need someone to help you understand the doctor?
a. Yes
b. No

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